

January 2015

Speak No Evil: Do Zambian Religious Leaders Practice a “Conspiracy of Silence” Regarding HIV/AIDS?

Corliss Lentz

Sam Houston State University

Sarmistha Majumdar

Texas Southern University

Follow this and additional works at: <http://digitalscholarship.tsu.edu/jpmssp>

 Part of the [Political Science Commons](#), [Public Affairs, Public Policy and Public Administration Commons](#), and the [Urban Studies and Planning Commons](#)

Recommended Citation

Lentz, Corliss and Majumdar, Sarmistha (2015) "Speak No Evil: Do Zambian Religious Leaders Practice a “Conspiracy of Silence” Regarding HIV/AIDS?," *Journal of Public Management & Social Policy*: Vol. 20 : No. 2 , Article 4.
Available at: <http://digitalscholarship.tsu.edu/jpmssp/vol20/iss2/4>

This Article is brought to you for free and open access by the Journals at Digital Scholarship @ Texas Southern University. It has been accepted for inclusion in Journal of Public Management & Social Policy by an authorized editor of Digital Scholarship @ Texas Southern University. For more information, please contact rodriguezam@TSU.EDU.

Speak No Evil: Do Zambian Religious Leaders Practice a “Conspiracy of Silence” Regarding HIV/AIDS?

Corliss Lentz
Sam Houston State University

Sarmistha Majumdar
Texas Southern University

“A Conspiracy of Silence” vilifies religious institutions for their perceived silence during the HIV/AIDS pandemic (Ngoma-Simengwa 2010). There have been few studies to determine whether clergy are silent about HIV/AIDS. This article reviews the 2011 Zambian Religious Leader’s Survey, which surveyed 336 clergy from two denominations in Zambia: Christians and Muslims. Twelve questions were used to identify the frequency of preaching on HIV/AIDS related topics. A factor analysis was used to select factors that were commonly addressed by Christian and Muslim clergy in their preaching, and each factor had several variables as topics of preaching. The t-test was used to determine if preaching on variable topics differed between the two religious groups. The study has helped to create a baseline database on HIV/AIDS church leadership in major denominations and determines that the conspiracy of silence is a myth. Clergy from two dominant religious groups do preach on difficult cultural issues to encourage a healthy lifestyle and are less likely to discuss cures resulting from joining the church or mosque.

The phrase “conspiracy of silence” is used in Zambia to vilify religious institutions for their perceived silence during the HIV/AIDS pandemic (Ngoma-Simengwa 2010). This condemnation results from views that religious leaders and organizations contributed to the spread of HIV/AIDS because of their silence. This manuscript uses the 2011 Zambian Religious Leader’s Survey (2011), compiled by the first author, who surveyed clergy of major denominations in Zambia, Christians and Muslims. Our research established a database of religious activity concerning HIV/AIDS and tested the veracity of the conspiracy of silence theory.

The research was conceived through another study conducted by the first author in which 102 men were interviewed from a population of 418 Zambian respondents with HIV/AIDS. Almost 80 percent of these men reported that they contracted HIV/AIDS

through multiple sexual partners. They also frequently attended a church or mosque (2010). Little research has been conducted to determine what is preached in churches or mosques about HIV/AIDS and personal behavior in Zambia. This research addresses this shortcoming.

The study has two purposes: First, to determine if Christian and Muslim clergy are preaching about HIV/AIDS, and second, to determine if there are statistically significant differences in the frequency of preaching on a particular topic by type of religion. Statistically significant differences may explain that the frequency of preaching on the topic was influenced by theology. If no statistical difference is found, an alternative explanation could be that clergy are more influenced by Zambian culture than by religious denomination.

Preachers may engage in different types of programs that educate congregations about HIV/AIDS. This article focuses solely on preaching because all members who attend services are exposed to the teaching. With other kinds of church programs, members can choose to forgo the classes. This manuscript presents background on Zambian culture and a literature review, discusses the methodology, presents descriptions of the research findings, and describes limitations of the research. Lastly, it makes recommendations for change.

Background: The United States President's Plan for HIV/AIDS Relief

Much of African society revolves around religious and cultural issues, both of which impact the moral fabric of society and influence the spread of HIV/AIDS (Trinitapoli 2009, 2011).

The U.S. President's Plan for HIV/AIDS Relief (PEPFAR) uses faith-based organizations (FBOs) to administer delivery of medical and educational services, which demonstrates the importance of FBOs in the fight against HIV (Churches Health Association of Zambia n.d., Patterson 2009, World Health Organization 2007).

The PEPFAR program uses numerous FBOs to deliver its two major initiatives, medical treatment for people with HIV/AIDS and education programs to prevent the spread of HIV/AIDS. The PEPFAR treatment program has been successful in preventing death, restoring health, and improving the quality-of-life for AIDS patients (U. S. President's Emergency Plan 2012).

The main education initiative employs interventions for youth including abstinence, "delay of sexual debut; mutual faithfulness and partner reduction for sexually active adults; and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV" (The United States President's Emergency Plan 2011,1). This ABC approach (A for abstinence, B for being mutually faithful, and C for regular, correct, and consistent condom use) has failed to curb the transmission of HIV or deliver programs to high risk groups to change behavior (Dhingra 2007). Only 38% of Zambian women aged 15-24 have a comprehensive knowledge of HIV (UNICEF, 2011, 1).

New infections may be declining across Zambia, but 185 new cases are diagnosed each day in Lusaka, the capital city (Shabongo 2013); thus, education programs need to continue. Part of the ABC's lack of success may be due to the dearth of health care providers available to conduct educational programs (Connell, Zurn, Stilwell, Awases, and Braichet 2007). Most of the health care workers have no time to conduct needed educational programs. New ideas must be found to expand educational resources. Connell et al. (2007) suggest that preachers of all denominations could expand from preaching about HIV/AIDS by incorporating educational programs in their churches and communities. The

research presented here suggests that clergy can and do act as health educators in their communities simply by preaching about HIV/AIDS in their sermons. But preaching is just the beginning. With proper training, preachers and other lay leaders could be developed into effective health educators in their congregations and communities.

Because of the sensitive nature of the discussion, the PEPFAR ABC program’s success needs promotion by respected voices in the community. As this research shows, Zambian clergy already are serving as health educators because they preach on a variety of related topics.

Literature Review: The Zambian Response—Silence or Exposure?

In 2005, Rev. Dr. D. T. Banda, lecturer at the Justo Mwale Theological University College in Lusaka, Zambia, explained that, historically, sexual matters were not discussed in general society or in family conversations (personal communication, June 5, 2005). Thus, he as a pastor and others in his denomination were reluctant to preach about anything related to sexual behavior such as HIV/AIDS. Since 2005, pastoral changes in preaching have emerged. Ngoma-Simengwa (2010) reports that clergy changed their attitudes and broken the church’s silence on HIV/AIDS upon their realization that their congregations were heavily impacted by the disease. Similar changes occurred in Nigeria (Ucheaga 2010).

Few studies examine the role of preaching in combating HIV/AIDS in Africa. Trinitapoli’s (2006, 2009 and 2011) studies are more comparable to the research reported here. She researched religious responses about HIV/AIDS through texts of sermons in Malawi. Malawi and Zambia share a border with common peoples, cultures, clans and traditions. Trinitapoli reported that “religious leaders often discuss AIDS in their weekly services (2006, 266).” Her findings may show more willingness by Malawians to preach about HIV/AIDS than Zambians. However, this willingness probably reflects a change in philosophy to address the pandemic which is now found in Zambia. Perhaps many African clergy were reluctant to preach about HIV/AIDS but had to change to address the pandemic surrounding their congregations.

Christians and Muslims

Two religions are evident in Zambia, Christians and Muslims. The mainline Christian denominations were established in the late 1800s. Presbyterians from Scotland founded the Central Church of Africa Presbyterian (CCAP) and the Reformed Church of South Africa established the Reformed Church in Zambia (RCZ). More charismatic churches, like Pentecostal/ Assembly of God, developed from a personal ministry led by missionaries and indigenous religious leaders. Pastors from both Christian and Muslim faiths were surveyed for this research.

Islam is a more recent entrant into Zambia than Christianity. Arabs may have made contact from time to time, but most recently missionaries from India entered Zambia during the 1970s and made inroads of growth in recent years (Phiri, 2008a; Phiri 2008b). According to Aadam Judas Phiri, HIV/AIDS Director for the Islamic Council of Zambia, there are currently over 200 Imams of various levels in Zambia (personal communication, January 26, 2014).

There are commonalities between the two religions that impact this research. The Koran, like the Bible, is clear about sexual behavior. Both books emphasize abstinence before marriage and fidelity after marriage, although Muslims may have four wives. Because of these shared beliefs, it is useful to compare the approaches to HIV/AIDS. Islamic programs now dispel the early notion that “a true Muslim cannot have HIV, or

cannot be HIV positive (Goldman 2008, 1).” Today Zambian Islamic leaders meld the Koran’s teachings with scientific teachings. There are numerous men’s and women’s groups that teach HIV/AIDS prevention (Goldman 2008). Estimates show that Christians make up 98 percent of the Zambian population while Muslims make up 2 percent (Tolerance and Tension 2010). But there are no published articles to show that Imams are preaching about HIV/AIDS or behavior change. Table 1 shows the distribution of the preachers between the two religions, Christian and Muslim, used for this study.

Table 1. Distribution of Respondents by Denomination Type.

Denomination Type	Number of Clergy	Percentage of Data
Christian	300	89.8%
Muslim	34	10.1
TOTAL	336	100.0

Source of Raw Data: The 2011 Zambian Religious Leader’s Survey.

The Impact of Religion on Personal Behavior

Religious leaders are highly esteemed members of their communities, and they often have great influence over their church members (Patterson 2009; Trinitapoli 2009, 2011). Since religious communities are the most common form of structured organization in Africa, the role of the religious leaders could be important in the dissemination of accurate information regarding HIV/AIDS (Pfeiffer 200; Trinitapoli 2009, 2011). Churches often have services that focus on the topic of HIV/AIDS, have support programs for people with HIV/AIDS, or caregiver programs to support families dealing with HIV/AIDS. However, preaching is the most basic form of education provided by all Christian and Muslim communities and is the way to communicate to the most people of all ages. Attending services with preached sermons are the most frequent form of religious participation where religious leaders have a captive audience to hear the message (Trinitapoli 2006). Over 75% of Zambians consider themselves either Christian or Muslim and attend services regularly, so sermons can reach a large number of people.

The Religious Response to HIV/AIDS: An Emerging Literature Base

There are a small but robust number of peer-reviewed articles bridging religion and reproductive health in Africa. The meta-analysis of articles linking religious responses to sexual health by Gaydos, Smith, Hogue and Blevins (2010) found only 52 articles relating to Africa. The authors call religion and reproductive health an “emerging” field, which is ripe for inquiry.

Several published manuscripts which will be discussed in the next section describe the role of church or mosque leaders in educating about HIV/AIDS in Sub-Saharan African communities in Burkina Faso, Malawi, Mozambique, Nigeria, the Republic of South Africa, Senegal, Uganda, and Zimbabwe. While the studies may not be generalizable to other countries like Zambia, they give a representation for the research inquiry related to religion and HIV/AIDS.

Studies of Church Organizations and Their Response to the HIV/AIDS Pandemic

The following articles show different forms of research designed for one commonality, to determine whether churches or church leaders can influence the HIV/AIDS pandemic. In

general they are country or religion specific and cannot be generalized to other settings.

Mozambique: Agedjanian and Menjivar (2008, 301) studied “how informal communication is used to reconcile the often conflicting secular and church messages” about HIV/AIDS in Mozambique by surveying members of different rural and urban Christian congregations. They found that members in urban, mainline denominations were more likely to engage in HIV/AIDS related conversations than church members in rural areas, particularly as they related to the discordance of church messages of chastity before marriage and marital faithfulness and the secular message of condom usage.

South Africa: Because churches had attracted controversy over how they have dealt with HIV/AIDS, Krakauer and Newbery (2007) studied what churches were doing on the grass-roots level to mitigate the effects of HIV/AIDS in their communities. The study, conducted in rural and urban areas outside of Durban, South Africa, examined three churches, Shembe, Zionist, and Roman Catholic, by interviewing church leaders and members about the types of HIV/AIDS education programs offered. The study reported that there was widespread awareness about HIV/AIDS. While the community and members used their churches as health resources, none of the churches studied offered AIDS programs. Krakauer and Newbery (2007, 34) conclude that “the Shemba and Zionist churches have scarcely responded to AIDS at all. The Shemba Church insisted that AIDS did not affect its members. Zionist ministers generally denounced the disease and those that have it.” The Catholic Church studied has a much lower membership than the others, so did not have the capabilities of starting effective HIV/AIDS health programs.

Uganda: Green, Halperin, Nantulya and Hogle (2006, 335) discussed the successful sexual behavior changes in Uganda by studying education programs in faith-based organizations (FBOs). The authors concluded that “behavior change programs, particularly involving extensive promotion of ‘zero-grazing’ (faithfulness and partner reduction), largely developed by the Ugandan government and local NGOs (including faith-based, women’s, people-living-with-AIDS, and other community-based groups) contributed to the early declines in casual/multiple sexual partnerships and HIV incidence and, along with other factors including condom use, to the subsequent sharp decline in HIV prevalence.”

Nigeria: Ucheaga and Hartwig (2010,611) examined HIV/AIDS religious communication by reviewing the formal policies of Christian and Muslim denominations and interviewed 48 Christian and Muslim leaders in Nigeria focusing on the denomination’s response to HIV/AIDS. Ucheaga and Hartwig (2010, 611) found that the study highlighted “differences in messages between mainstream and Pentecostal Christians and Muslims. Although all groups stated a core message of abstinence outside marriage, Pentecostal churches tended to have more messages of punishment and condemnation for people infected with HIV/AIDS.”

Senegal: Gilbert (2008) focused on Islam and health. She surveyed students in Senegal and found that students with high levels of religiosity practiced less risky behavior that might prevent HIV/AIDS, but religiosity was more linked to personal attitudes rather than formal attendance at mosque services.

All of these studies show that most of the time, church or mosque organizations have an influence among their members regarding sexual behavior. The following studies took the next step by surveying or interviewing leaders regarding their church activities or preaching about HIV/AIDS. Few studies actually surveyed or interviewed religious leaders. Marshall and Taylor (2006) and Trinitapoli (2006, 2009 and 2011) are the exceptions.

Studies that Survey Religious Leaders about Congregational Action about HIV/AIDS

Burkina Faso, South Africa, Zimbabwe: Marshall and Taylor (2006, 365) “interviewed key staff members in organizations working within the church” including pastors and church members in Burkina Faso, South Africa, and Zimbabwe. Their findings suggest that “gender is one of the keys to the response to AIDS in Africa, because it is often the imbalance in power relations between men and women that drives the spread of HIV through heterosexual relationships” (Marshall and Taylor 2006, 365-366). They also reported that most respondents believed that it was inappropriate for pastors to speak about sex.

Malawi: Trinitapoli’s (2006, 2009, 2011) studies show an extensive pattern of research in Malawi. Her 2006 article studies three themes, exploring the extent that religious leaders discussed HIV/AIDS in their churches and mosques, examining the organizational structures within churches and mosques that curb risky behavior, and documenting the types of program churches used to manage the AIDS crisis. Her findings show that religious leaders discussed AIDS often in sermons but were more likely to focus on abstinence and fidelity. It was unclear whether individuals changed their behavior because of sermons. References to HIV/AIDS in sermons were analyzed.

Trinitapoli continued her research in Malawi (2009), which studied how religious organizations impacted the sexual behavior of members and determined if their members are more likely to adhere to the ABCs of HIV/AIDS prevention than members of other types or organizations present to their congregations. She found that congregations were “led by clergy who 1) frequently deliver formal messages about HIV, 2) monitor the sexual behavior of members, and 3) privately encourage condom use report greater adherence to the ABCs of HIV prevention” (Trinitapoli 2009,199). This finding suggests that religious congregations are relevant in shaping the sexual behavior of their members.

Trinitapoli’s (2011) study is a continuation of her Malawi work. She interviewed 187 religious leaders (priest, pastor, or sheik) on their HIV/AIDS preaching topics because preaching is the most common way that religious leaders discuss HIV. Preachers reported that 72 % preached on HIV/AIDS or morality topics once a week. This article was the most useful for the study presented in this manuscript. Many of the questions used by Trinitapoli (2011) regarding preaching about HIV/AIDS, preaching about sexual morality, promoting condom use, and promoting testing for HIV were incorporated into the surveys used in our research.

The Impact of Culture on Personal Behavior

HIV/AIDS permeates the social, religious, political, and economic fabric of Zambian society. As noted in a USAID report,

In Zambia, high prevalence rates [of HIV/AIDS] are fueled by early initiation of sex, unprotected sex with non-regular partners, concurrent sexual partnerships, low incidence of condom use among high risk groups and individuals, sexual violence against women, and poverty that forces women and girls to sell sex for food, good grades, small gifts, or money. The most at risk individual in Zambia, however, is the seronegative partner in a discordant couple. (USAID 2011, 1)

Others (2010; USAID 2011) found that 80% of the Zambian women surveyed reported they were infected with HIV/AIDS by their husbands. Monogamous relationships are more often given lip service instead of practiced.

According to Zambia’s Ministry of Health (2008), the HIV/AIDS infection rate

was 20.0% in 2000. But Zambia’s HIV infection rate dropped to 14.3% by 2008 (Central Statistical Office 2009). Because of the high persistent infection rate, HIV/AIDS dominates the discussion in the health and educational sectors. It is reported that men are more likely than women to transmit the disease and are thus considered to be the origin of HIV transmissions (Brown, Sorrell and Raffaelli 2005; Ministry of Health 2008). Zambia’s society is dominated by male sexuality. Men are encouraged to have multiple concurrent sexual partners (MCSPs) because this behavior increases their standing among their peers; having only one partner suggests poverty, low status, and impaired manhood (Brown et al. 2005; Nshindano and Maharaj 2008). This notion is embedded; male virility is measured by having multiple wives or girlfriends, engaging in unprotected sex, and having many children (Ministry of Health 2008).

Ndubani, Bond, Liljeström, and Höjer (2003) explored the sexual behavior of 433 men, aged 16 to 25, in Chiawa, Zambia. These authors note that children were seen as symbols of prosperity in the clan, symbols of “real manhood” in the community. The men received respect for producing large families, which are considered to be security for their old age. These factors overrode any worries of HIV exposure in their relationships. The authors concluded that “early sexual initiation and multiple premarital partners may establish a pattern of sexual conduct that persists into later life” (Ndubani et al. 2003, 294). Zambia’s Demographic and Health Study (Central Statistical Office 2009) showed that the more sexual partners one had, the greater the likelihood of HIV/AIDS infection. The study also showed that the pattern of multiple sexual partners is not limited to men. Women also may have MCSPs. Money and gifts from multiple boyfriends can help lift women out of poverty and provide school fees for young women, thus, the reasons for women to collect multiple partners (Nshindano and Pranitha 2008).

Married and unmarried Zambian men often have MCSPs. This practice of engaging in long-term overlapping partnerships is common in southern Africa as shown in Lesoto (Halprin and Mah 2008), Malawi and Uganda (Bardan-o’Fallon et al. 2004), and Zambia (Do and Meekers 2009). The sexual behavior of some Zambian political leaders may be part of the problem. Dr. Kenneth Kaunda, first president of the Republic of Zambia, appealed to political leaders to “lead by example by not having multiple concurrent partners as their behavior may influence the youth. They need to ... change from harmful social norms ... that facilitate the spread of HIV” (Mbulo 2010, 5). Changing this behavior lies at the crux of managing the pandemic.

Methodology

This research investigated religious leadership and pastoral care through preaching topics related to HIV/AIDS. The following section explains the survey format and data collection.

Survey Design

For the research, surveys were conducted with ordained pastors, Imams, and preaching leaders. Because both religions lack enough clergy to fill the pulpits of churches or mosques, both the Christian and Muslim faiths also rely on non-ordained leaders for preaching on Fridays or Sundays. In the survey, 12 questions related to preaching on HIV/AIDS were posed to the respondents. Each question had five possible answers in a Likert-style format. It took approximately 45 minutes to complete the survey. The surveys were blind; respondents’ names were not linked to the surveys.

Prior to administration of the survey, the research project was approved by The Institutional Review Board of Sam Houston State University and The Ethics Board of The

University of Zambia. The General Secretaries for both Central Church Africa Presbyterian (CCAP) and Reformed Church of Zambia (RCZ) granted permission to field the survey at their synod meetings in August, 2010. Each denomination reported that about 92 % of their pastors attended the CCAP and RCZ synod meetings (personal communication, Rev. D. T. Banda, April 9, 2013). The CCAP meeting was held in Lusaka, the RCZ meeting in Katate. The Islamic Council of Zambia gave permission to field the survey and invited Muslim leaders to be surveyed at two focus group meetings in Lusaka and Ndola in 2011.

A sample of convenience was used in administration of the survey; all persons attending the meetings were surveyed. The surveys for the Muslim clergy were also samples of convenience. Charismatic leaders were surveyed one-on-one because those denominations do not have synod or clergy meetings. All respondents provided a written signature for Informed Consent. Once the signatures were obtained, an Information Sheet was distributed to all respondents.

The survey response rate was 100 % for clergy attending the synod meetings, but some surveys had missing answers to some of the questions since participation in the survey was voluntary. Only 4 surveys missed too many questions to be usable. Most of the questions were answered by the Muslim leaders. The high response rate can be partly attributed to the small gifts that were offered to some of the respondents. For example, only respondents from the Reformed Church of Zambia and the Muslim clergy were offered incentives. The Principal Investigator entered all data in Microsoft Excel and imported the file into the IBM SPSS Statistics ver. 20.0.

Data Collection

In the study, the main analysis is based on 12 preaching topics which were asked in survey question 2, sub-questions a-s (Trinitapoli 2006). Question 2 asks, "In the past 12 months, how often have you preached on the following topics?" Each question had five possible answers in a Likert-style format including "once a week," "once a month," "once a quarter," "rarely," or "I have never preached on this topic." The small number of responses in each answer option prompted its recoding into a single distinct category in the study. For example, the "once a week," "once a month," and "once a quarter" were recoded into "frequently," while "rarely" and "never" responses were recoded into "rarely."

Statistical Methods Used In the Study

Three types of statistical methods were used to test the hypotheses in our research. The statistical methods ranged from simple descriptive measures to factor analysis and *t*-tests. The choice of descriptive measures rested on the fact that it helped to provide some basic information on each variable. The reliance was mainly on frequencies of preaching for each topic by denomination and was later used to augment the *t*-test analysis.

The statistical procedure of factor analysis was used in the study because of its utility as a data reduction tool. It has the ability to remove redundancy from a set of correlated variables and derive only those variables that can be grouped into independent factors. Hence, this method has become a common choice among scholars in the study of the influence of religions on human behavior (Underwood and Teresi 2002; Pargement, Konig and Perez 2000). In our study, the method has helped to reduce the 12 preaching topics into 4 principal components with 12 statistically significant components.

The selection of *t*-tests in the analysis of data in the study can be justified on the grounds that it makes comparison possible between two groups using mean differences. The

t-test has been used to compare all 12 significant preaching topics to determine if there were statistically significant differences in the frequency of preaching on the topic, $p < .05$. The *t*-tests determined whether there were statistically significant variations in the frequency of preaching which could be attributed to religious or theological variations. Otherwise, if there was no difference between the groups, the assumption was that Zambian culture was more definitive than theology in determining the frequency of preaching on the topic.

Data Reduction Using Factor Analysis

A factor analysis with a varimax rotation helped to reduce the 12 preaching topics to four principal components with 12 variables. Variables for each principal component were selected from the rotated component matrix with values $\leq .500$. The derived Kaiser-Meyer-Oiken value of .778, which is a coefficient that is considered “middling,” shows that the data were adequate for a factor analysis (George and Mallory 2010). Table 2 shows the Principal Components and their eigenvalues; the four principal components are listed in order of importance by their eigenvalue.

- Principal Component 1 shows that 20.5 % of the variance in preaching is related to the frequency of preaching about a healthy lifestyle.
- Principal Component 2 shows that 12.5% of the variance in preaching is related to the frequency of preaching about HIV/AIDS misinformation.
- Principal Component 3 shows that 10.0% variance in preaching is related to the frequency of preaching encouraging marital fidelity.
- Principal Component 4 shows that 9.3% variance in preaching is related to the frequency of preaching to encourage condom use.

Overall, 53.3% of variance in preaching can be explained by the four components in the model.

Table 2. Principal Components Identified by Factor Analysis Including Eigenvalues

Principal Component	Preaching Topics	Eigenvalue	% of Variance	Cumulative %
1	Frequency preaching about healthy lifestyles	2.667	20.513%	20.513%
2	Frequency preaching about HIV/AIDS misinformation	1.624	12.495	33.008
3	Frequency preaching encouraging marital fidelity	1.301	10.006	43.014
4	Frequency Preaching to encourage condom use	1.207	9.287	52.301

Source of Raw Data: The 2011 Zambian Religious Leader’s Survey.

Composition of Principal Components and Justification for Choice of Preaching Topics

This section gives the background for using each question. All 12 sub-questions loaded on one of the four components.

Principal Component 1: Sermon Topics Related to Preaching Encouraging a Healthy

Lifestyle

Principal Component 1 uses 7 of the 12 sub-questions in question 2, questions 2e, 2g, 2i, 2h, 2j, 2k, and 2o. Question 2e asks: “In the past 12 months, how often have you preached to encourage monogamy?” According to Isaak (2006), the issue is not polygamy itself, but the need for sexual faithfulness to be practiced by all partners in the marriage.

Question 2g asks: “In the past 12 months, how often have you preached to encourage HIV testing?” There is some resistance to voluntary counseling and testing (VCT) for HIV/AIDS because people fear stigma by their communities, churches, and families. There is some justification for these concerns, but there is much variability to stigma that depends on the community, church congregation, or family (Trinitapoli 2006).

Question 2h asks: “In the past 12 months, how often have you preached to discourage violence against women?” Gender inequality is one of the cultural problems in some African communities which include polygamy, wife battering or mutilation, and child marriages. These issues put destructive traditional, cultural, and social demands on women (Oloo 2008).

Question 2i asks: “In the past 12 months, how often have you preached to discourage child marriages?” Child marriages, often arranged by parents for a bride price, are practiced by several tribes in Zambia, particularly in rural areas. Some girls as young as 12 or 13 are forced to end their schooling and marry. Many marry older men who may already have HIV, and therefore these young girls are often exposed to HIV at an early age (Mulenga 2010).

Question 2j asks: “In the past 12 months, how often have you preached to discourage discrimination (stigma) against people with HIV/AIDS?” Stigma is a discrimination against people with HIV/AIDS. Many people would rather die from HIV/AIDS than have people in the community know they are HIV positive and judge their behavior. “Children and disempowered widows are disposed and are thrown out of their homes and communities” Oloo (2008, 71).

Question 2k asks: “In the past 12 months, how often have you preached to equate adultery with murder, i.e., infecting an innocent spouse or partner with HIV/AIDS?” Trinitapoli (2006: 261) found this extreme view often preached in Malawi; “the sin of adultery was equated with murder, arguing that—in the era of AIDS—the consequences of these two sins are the same.” For Isaak (2006), using a condom might be the best way to obey “thou shalt not kill,” particularly when one partner is seronegative.

Question 2o asks: “In the past 12 months, how often have you preached to encourage HIV prevention?” The most common cause of HIV infection is promiscuity; thus, behavior change is the best way to protect people from HIV/AIDS. Preaching on this topic suggests that discussing prevention and changing behavior might be gaining more cultural acceptance.

Principal Component 2: Sermon Topics Related to Preaching About HIV/AIDS Misinformation

Two questions are related to preaching about HIV/AIDS misinformation, Q2n, and Q2p. Question 2n asks: “In the past 12 months, how often have you preached that membership in your church can heal HIV/AIDS?” Anecdotal reports suggest that some church leaders preach that membership in their church will cure a person of HIV/AIDS (Kalaluka 2010.)

Question 2p asks: “In the past 12 months, how often have you encouraged members to stop taking ARVS and rely on faith in God for healing?” Anti-Retroviral treatments

(ARVS) are the drug therapies used by physicians to treat people with HIV/AIDS. Anecdotal evidence suggests that some church leaders encourage people with HIV to stop taking their ARVS because prayer or membership in the church will cure HIV. According to a Ministry of Health Care Programme Officer, Veronica Muntanga, one of the challenges is convincing patients to remain on their treatment. Patients often relapse after stopping their ARVs (Kalaluka 2010).

Principal Component 3: Sermon Topics Related to Preaching Encouraging Marital Fidelity

Two questions are related to Principal Component three, Q2b and Q2f. Question 2b asks: “In the past 12 months, how often have you preached to encourage sexual fidelity to spouse or partner?” Sexual fidelity assures a man that his wife will only bear his children, and the wife can be sure no children will be born out of wedlock to her husband by another woman.

Question 2f asks, “In the past 12 months, how often have you preached to encourage polygamy as a replacement for relationships outside of marriage?” Some believe that polygamy can provide protection against HIV/AIDS because “polygamous men are less likely to seek sexual partners outside of their family” (Trinitapoli 2006, 261). All partners should be faithful.

Principal Component 4: Sermon Topics Related to Preaching about Condom Use

Only one question relates to this topic. Question 2d asks, “In the past 12 months, how often have you preached to encourage condom use? Zambians are reluctant to preach about condom use because even though it reduces the risk of pregnancy, it is seen as an intrusion into personal marital matters. Table 3 shows differences in the frequency of preaching on the topics that loaded on the four principal components. The *F* values and significance levels are also shown.

Selecting Statistically Significant Variables Using *t*-Tests

As previously described, the *t*-test was used to compare the differences in preaching topics among the two different religious groups, Christians and Muslims. The *t*-test method for two independent samples was chosen because the data were derived from two different samples (Gravetter and Wallnau 2007). These two independent samples were drawn from the populations of Christian and Muslim clergy in Zambia. The Christian preachers (*n* = 300) were from several Charismatic and Missional denominations. The Muslim preachers (*n* = 34) were from a single denomination. The *t*-test helped to determine the presence of statistically significant differences, if any, between the two religious groups on the preaching of topics related to healthy lifestyle, misinformation on HIV/AIDS healing, fidelity among sexual partners, and condom use. The preaching topics tested correspond to the principal components derived from the factor analysis.

Results for Preaching about Healthy Lifestyles

For healthy lifestyles, *t*-tests were used to calculate the mean differences, if any, in the frequency on preaching by Christians and Muslim on the topics of monogamy, voluntary counseling and testing (VCT), violence against women, child marriage, attachment of stigma to HIV/AIDS infection, equating HIV infection with murder, and HIV prevention.

From the *t* values on these variables, it is evident that there exist statistically significant differences between the two religious groups in the frequency of preaching on VCT (85.1% for Christians, 70.6% for Muslims), violence against women (85.0% for Christians, 76.5%

for Muslims), elimination of child marriages (84.7% for Christians, 73.5% for Muslims), reducing stigma attached to HIV/AIDS (92.0% for Christians, 64.7% for Muslims), and in HIV/AIDS prevention (92.1% for Christians, 67.6% for Muslims (Table 4). Two variables did not show statistical significance— preaching to encourage monogamy, and preaching which equates HIV transmission with murder.

Table 3. Results of *t*-Test Analysis for Christian and Muslim Preachers on Variables Measuring the Means of the Frequency of Preaching on HIV/AIDS Related Topics, Difference of Means *F* Scores, and Significance Levels

	Sermon Topics	Freq	Rarely	Freq	Rarely	F-values	Sig. level
1	Frequency Preaching About a Healthy Lifestyle						
	2e. Encourage monogamy	80.2	19.8	21.2	78.8	.144	.705
	2g. Encourage VCT	85.1	14.9	70.6	29.4	13.175	.000
	2i. Encourage elimination of child marriages	84.7	15.3	73.5	26.5	8.511	.004
	2h. Encourage eliminating violence against women	85.0	15.0	76.5	23.5	5.453	.020
	2j. Encourage reduction of HIV/AIDS stigma	82.0	14.0	64.7	35.3	22.465	.000
	2k. Equate HIV transmission to murder	57.7	42.3	61.8	38.2	1.109	.293
	2o. Encourage HIV Prevention	92.1	7.9	67.6	32.4	52.909	.000
2	Frequency Preaching about HIV/AIDS Misinformation						
	2n. Suggest that church or mosque membership can cure HIV/AIDS	25.7	74.3	5.9	94.1	48.838	.000
	2p. Encourage members to stop ARVS and let God heal them	12.2	87.8	17.6	82.4	2.892	.090
3	Preaching Encouraging Marital Fidelity						
	2b. Encourage marital fidelity	75.7	24.3	82.4	17.6	3.587	.059
	2f. Encourage polygamy as a replacement of MCSPs	16.5	83.5	51.5	48.5	26.464	.000
4	Preaching Encouraging Condom Use						
	2d. Encourage condom use	42.4	57.6	9.4	90.6	265.262	.000

Source of Raw Data: The 2011 Zambian Religious Leader's Survey.

In calculation of the *t*-test values, since the means in frequency of preaching by Muslim clergy on variables related to healthy lifestyles were subtracted from that of Christian clergy, the negative *t* values suggest that the Muslim clergy are less likely to preach on those variable topics pertaining to healthy lifestyle in comparison with that of the Christian clergy. These differences may be based on theological differences

Results for Frequency of Preaching about HIV/AIDS Misinformation

For this component, two variables showed statistically significant differences between the Christian and Muslim clergy on their frequency of preaching. The variable suggesting that church or mosque membership could cure HIV/AIDS (25.7% for Christians, 5.9% for Muslims) has a negative *t* value and is statistically significant, showing that Muslim clergy are less likely to preach on this topic in comparison to Christian clergy. The second variable of preaching, to stop ARVS and God will heal (12.2% for Christians, 17.6% for Muslims), has a small positive *t* value and has a weak statistical significance, suggesting the variations on frequency of preaching on this variable is more likely to be culturally driven rather than theologically driven.

Results for Frequency of Preaching to Encourage Marital Fidelity

The frequency of preaching on marital fidelity (75.7% for Christians, 82.4% for Muslims) and that polygamy is a replacement for multiple concurrent sexual partners (16.5 % for Christians, 51.5% for Muslims) showed statistical significance, but the association is weak for marital fidelity. Muslim clergy are more likely to preach on these topics in comparison to that of Christian clergy.

Results for Frequency of Preaching to Encourage Condom Use

There exists a statistically significant difference between the two religious groups (42.4% for Christians, 9.4% for Muslims) on preaching about condom use. The negative *t* value indicates that the Muslim clergy are less likely to preach on this topic in comparison to that of the Christian clergy.

Research Findings: Pastoral Care through Preaching on Topics Related to HIV/AIDS

This section reviews the research findings to determine whether the investigation achieved its goal. Also, it analyzes whether there is a “conspiracy of silence” among Zambian clergy.

Finding 1: The data are robust

Data were collected from ordained clergy from five major denominations in Zambia. Of the 336 surveys, 97.9% were usable. The Kaiser-Mayer-Olkin measure determined that the distribution of values was sufficient for a factor analysis. The results of this attempt at surveying church clergy were surprisingly robust; there is ample evidence to show that a base-line database of 336 respondents from around the country was achieved.

Finding 2: The “conspiracy of silence” may be a myth

Prior to 2005 a “conspiracy of silence” probably existed. As Banda suggested, no pastor wanted to preach about sexual matters (personal communication with first author, June, 2005). Marshall and Taylor (2006) also report that most respondents believed that it was inappropriate for pastors to speak about sex. However, the cultural view may be changing. This research shows that Pastors and Imams preach

about HIV/AIDS to protect their members. Negoma-Simengwa (2010) noted that HIV/AIDS changed the Zambian culture.

The respondents, a variety of clergy from various denominations and locations throughout Zambia, were willing to preach on difficult cultural issues identified in Principal Component One, encouraging a healthy lifestyle. Over 60% of the respondents preached frequently on 6 of the 7 variables in Principal Component One. With the exception of preaching to encourage monogamy, clergy preached frequently (above 50%) on all of the variables associated with Principal Component One, healthy lifestyles—encouraging sexual abstinence, marital fidelity, monogamy, voluntary counseling and testing and HIV prevention; eliminating violence against women; reducing child marriages; and reducing HIV stigma. Many of these preaching topics run against cultural norms, particularly in regard to treatment of sexual relationships; however, the respondents were willing to preach frequently on them.

Clergy are more likely to preach on HIV issues that are part of the education encouraged by PEPFAR. They are much less likely to preach about unhealthy practices such as cures that have come from joining a church or mosque or encouraging members to stop taking ARTs. This research shows the pandemic has opened the “conspiracy of silence” regarding HIV/AIDS.

Finding 3: Religion, rather than culture, may cause more unity among clergy

The respondents may have more preaching differences based on theology or religion than culture. Ten of the 12 preaching topics showed statistically significant preaching variations among the clergy. An examination of the percentages of clergy preaching frequently on the topics overall shows that although Muslims were less likely to preach on HIV/AIDS topics than Christians, they also preached often on these topics.

Table 4. *t*-test variables Comparing Mean Scores for Christians and Muslims

Category / Preaching Variable	<i>T</i>	Sig. <i>t</i>	n=Christians	n=Muslims
Healthy Lifestyle				
Preach to encourage monogamy	.144	.705	283	33
Preach to encourage VCT	-2.162	.000***	288	34
Preach to eliminate violence against women	-1.288	.020*	287	34
Preach to eliminate child marriage	-1.667	.004***	288	34
Preach to reduce HIV/AIDS stigma	-3.093	.000***	289	34
Preach equating HIV transmission with murder	0.447	.293	265	34
Preach encouraging HIV prevention	-4.544	.000***	292	34
Preaching about HIV/AIDS Misinformation				

Preach that church/mosque membership heals HIV	-2.584	.000****	269	34
Preach to stop ARVS and let God heal	0.899	.090*	271	34
Preaching to Encourage Marital Fidelity				
Preach encouraging marital fidelity	0.861	.059*	259	34
Preach encouraging Polygamy as a replacement for MCSPS	4.860	.000****	260	33
Preaching to encourage condom use				
Preach to encourage condom use	-3.693	.000****	276	31

Source of Raw Data: The 2011 Zambian Religious Leader's Survey.

Statistical Significance Levels: * = .10 level; ** = .05 level; *** = .01 level; **** = .000 level

Study Limitations

This study has two shortcomings that limit generalizability to other settings. First, most of the Christian clergy were from mainstream denominations. It is clear from the literature review that Charismatic Pastors and congregations have different opinions about HIV/AIDS than mainstream Christians. Thus, respondents' preaching activities may not be generalizable to other denominations, particularly those who believe that their members are not infected with HIV/AIDS (Marshall and Taylor 2006).

Second, only 30 Imams were surveyed for this study, which is a relatively a much smaller sample than the number of Christian Pastors. However, there are not very many Imams in Zambia. These Muslim respondents came from two of the most populous cities in Zambia or nearby rural communities. There are other Imams primarily located in small communities in the Copperbelt or Eastern Provinces. Because of poor road conditions and their location in small, rural towns, these Imams would be difficult to survey. However, even with the small number of Imams surveyed, there are no published studies reporting surveys or interviews with Imams about HIV/AIDS, which makes this a unique study.

There were other problems with the conduct of the research that need to be addressed in the future. First, the CCAP respondents were pressed for time to complete the surveys compared to the other denominations and were more likely to leave more questions unanswered. Sufficient time is needed to complete the surveys and to ensure that all questions are answered. Second, a “don't know” designation for the preaching topics should be included. This addition may make the survey answers easier for respondents to understand. Third, expand the database to include Catholic and more charismatic clergy.

The Roman Catholic Church is one of the largest denominations in Zambia and holds political influence. In light of the similarities between these denominations, their addition probably would not change the results found. However, their inclusion would give more diversity and stability among denominations and would give a more expansive picture of the topic. Also, the literature suggests that charismatic congregations have different opinions about HIV/AIDS than mainstream congregations. More surveys from these pastors might emphasize that fact. Last, research including the Islamic Council of Zambia to reach rural Imams in the Copperbelt and Eastern Provinces would expand the number of Imams surveyed.

Recommendations for Religious Denominations

The following recommendations are based upon the findings of our research:

Recommendation 1: As clergy of both religions take on greater health education roles, they should strive to reduce the tendency to preach misinformation. After all, 12.5% of the variance was attributed to preaching misinformation. If denominations could present HIV/AIDS educational workshops at synod meetings or focus groups, this might dispel misinformation.

Recommendation 2: Clergy need to resolve the “disconnects” of the PEPFAR ABC program. One of the topics related to PEPFAR, preaching on abstinence, fell out of the model, suggesting that Muslims and Christians have similar cultural values on the topic. The big difference found is preaching on condom use, 42.4% Christians and 9.4% for Muslims. If church and mosque members do not practice abstinence and faithfulness, condoms should be promoted to prevent new cases of HIV.

Recommendation 3: Eradicate stigma in churches and mosques because it hinders voluntary counseling, testing (VCT), and treatment. Christians were more likely to frequently preach against stigma (82.0%) than Muslims (64.7%). The Islamic Council of Zambia can encourage Imams to preach more frequently on the topic.

Conclusion

The 2010/11 *Zambian Church Leader’s Survey* is a first attempt to determine if church and mosque leaders are speaking out about HIV/AIDS in Zambia. As such, it provides path-breaking data that debunks the “conspiracy of silence” theory for Christian and Muslim preachers. These respondents frequently preach on HIV/AIDS topics and address the difficult topics of polygamy, adultery, promiscuity, violence against women, and stigma.

Two issues are problematic within the denominations. First, a few clergy are preaching misinformation that can be harmful to people with HIV/AIDS. As leaders take on more educational roles, they need to know the facts about HIV/AIDS (USAID 2010).

Second, *Zambian men* claim that their promiscuous sexual behavior is their tradition (2010). However, that tradition is killing *Zambians*. The high rate of HIV/AIDS infections in Zambia indicates that many men who are sitting in church pews or mosques are not listening to the message from their Pastors or Imams. This problem is cross-denominational and is indicative of its cultural entrenchment in Zambia.

The message is clear: HIV/AIDS cannot be halted without behavior change by people with HIV/AIDS, and that message best comes from clergy who are well respected leaders in their communities. HIV/AIDS can only be stopped when those with HIV consider the importance of protecting their sexual partners from infection. Sexual responsibility must become the next frontier for the church because, without behavior change, sub-Saharan countries like Zambia are doomed to remain on the HIV/AIDS roller coaster, where the social fabric of the country is woven by disease and sewn with pain and sorrow. Clergy can help ameliorate this problem.

Authors’ Biographies

Corliss Lentz’s PhD in Political Science is from Northern Illinois University. Currently she is an Associate Professor in the Department of Political Science at Sam Houston State

University where she teaches policy, public administration, and methods courses. She has published articles in peer reviewed journals and received grant funding for research. In 2010, she received the Fulbright Scholar Award for research and lecturing at the University of Zambia

Sarmistha R. Majumdar is an associate professor in the MPA and e-MPA program at Barbara Jordan and Mickey Leland School of Public Affairs at Texas Southern University. With a background in policy analysis and program evaluation, she has published articles in peer reviewed journals, written grant and research reports, and presented research findings at various public meetings, webinars, and conferences.

References

- Agadjanian, Victor and Cecila Menjivar. 2008. “Talking about the ‘Epidemic of the Millennium’: Religion, Informal Communication and HIV/AIDS in Sub-Saharan Africa,” *Social Problems* 55(3): 301-321.
- Barden-O’Fallon, J. L., T. J. deGraft-Johnson, T. Bisika, S. Sulzbach, A. Benson and A. O. Tsui. (2004). “Factors Associated with HIV/AIDS Knowledge and Risk Perception in Rural Malawi.” *AIDS and Behavior*, 8: 131-140.
- Brown, Jill, James Sorrell and Marcela Raffaelli. 2005. “An Exploratory Study of Constructions of Masculinity, Sexuality and HIV/AIDS in Namibia, Southern Africa.” *Culture, Health & Sexuality*. 7: 585.598.
- Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. “Zambia Demographic and Health Survey 2007. Retrieved from <http://www.measuredhs.com/pubs/pdf/FR211/FR211%5Brevised-05-12-2009%5D.pdf>.
- Churches Health Association of Zambia. 2013. “Welcome to CHAZ.” Retrieved from <http://www.chaz.org.zm>.
- Connell, John, Pascal Zurn, Barbara Stilwell, Magda Awases, & Jean-Marc Braichet. 2007. “Sub-Saharan Africa: Beyond the Health Worker Migration Crisis?” *Social Science & Medicine*, 64: 1876-1891.
- Dhingra, Naina. 2007. “Improving U.S. Global AIDS Policy for Young People: Assessing PEPFAR, Executive Summary.” Retrieved from <http://www.advocatesforyouth.org/publications/594/tasks=view>.
- Do, Mai and Dominique Meekers. (2009) “Multiple Sex Partners and Perceived Risk of HIV Infection in Zambia: Attitudinal Determinants and Gender Differences,” *AIDS Cure*, 10: 1211-1221.
- Gaydos, Maura M., Alexandria Smith, Carol J. R. Hogue, and John Blevins. 2010. “An Emerging Field in Religion and Reproductive Health,” *Journal of Religion and Health*, 49:473-484. DOI: 10.1007/s10943-010-9323-1.
- George, Darren and Paul Mallery. 2010. *SPSS for Windows Step-by-Step: A Simple Study Guide and Reference, 17.0 Update, 10th edition*. Boston: Allyn & Bacon.
- Gilbert, Sarah S. 2008. “The Influence of Islam on AIDS Prevention Among Senegalese Students.” *AIDS Education and Prevention* 20(5): 399-407.
- Goldman, Bonnie. 2008. “A Look at HIV/AIDS and Muslims in Zambia.” *The Body*, September 2008. Retrieved from <http://thebody.com/content/art55076.html>.

- Gravetter, Frederick J. and Larry B. Wallnau. 2007. *Statistics for Behavioral Sciences*, 7th edition. Thompson Wadsworth.
- Green, Edward C., Daniel T. Halperin, Vinand Mantulya, and Janice A. Hogle. 2006. "Uganda's HIV Prevention Success: The Role of Sexual Behavior Change and the National Response," *AIDS and Behavior*, 10(4):335-346.
- Halprin, D. T. and T. Mah. 2008. "Concurrent Sexual Partnerships and the HIV Epidemics in Africa: Evidence to Move Forward," *AIDS Behavior*. Retrieved from http://www.ngoconnect.net/c/document_library/get_file?p_l_id=36853&folderId=151386&name=DLFE-9742.pdf
- Isaak, Paul John. 2006. "Luke 15:1-10: Searching and Finding Solutions," p. 1233-1255 in *African Bible Commentary*, ed. Tokunboh Adeyemo. WordAlive Publishers, Nairobi.
- Kalakuka, Mwala. 2010. "Adjustment in Start-up Time for ART Poses Challenge." *The Post Newspapers Zambia*. October 11, retrieved from http://www.postzambia.com/post-print_article.php?articleid=14535.
- Krakauer, Mark and Jodie Newbery. 2007. "Churches' Responses to HIV/AIDS in Two South African Communities." *Journal of the International Association of Physicians in AIDS Care*, 6:27-35.
- Marshall, Mandy and Nigel Taylor. 2006. "Tackling HIV and AIDS with Faith-Based Communities: Learning From Attitudes on Gender Relations and Sexual Rights within Local Evangelical Churches in Burkina Faso, Zimbabwe, and South Africa." *Gender and Development* 14(3): 363-374.
- _____. 2010. "Evaluating the President's Emergency Plan for AIDS Relief (PEPFAR) through Interviews of People with HIV/AIDS in Zambia: Research Notes." Department of Political Science, Sam Houston State University. Unpublished manuscript.
- _____. 2011. "Zambia Religious Leaders Study." Department of Political Science, Sam Houston State University. Unpublished data set.
- Mbulu, Edwin. 2010. "KK Appeals Against Multiple Sexual Partners Among Leaders." *The (Zambian) Post*. May 16, 2010, p. 5.
- Ministry of Health. 2008. *Zambia Country Report: Multi-sectoral AIDS Response Monitoring and Evaluation Biennial Report 2006-2007, Update Version, Submitted to the United Nations General Assembly Special Session on AIDS, Declaration of Commitment*, 2008, retrieved from http://data.unaids.org/pub/Report/2008/Zambia_2008_country_progress_report_en.pdf
- Mulenga, Prudence. 2010. "Itezhi Tezhi Parents Marry Off Daughters in Exchange for Cattle: Practice Forces Children Out of School, Exposes Them to HIV/AIDS." *The (Zambian) Post*, March 20, p. IX.
- Ndubani, Phillimon, Virginia Bond, Rita Litjeström, and Bendl Höjer. 2003. "Understanding Young Men's Sexual Health and Prospects for Sexual Behaviour Change in Rural Zambia." *Scandinavian Journal of Public Health*. 31: 291-298
- Ngoma-Simengwa, Jessie. 2010. "Zambia: Local Clergy Breaking Silence on HIV/Aids." 27 March 2010. *Times of Zambia*. Retrieved from <http://allafrica.com/stories/printable/201003290409.html>.
- Nshindano, Chama and Pranitha Maharaj. 2008. "Reasons for Multiple Sexual Partnerships: Perspectives of Young People in Zambia." *African Journal of AIDS Research* 7: 37-44.

- Oloo, Pamelah. 2004. “The Church’s Mission: Gender and HIV/AIDS Among the Luos of East Africa.” *Transformation*. 21: 70-77.
- Pargament, Kenneth I., Harold G. Koenig, and Lisa M. Perez. 2000. “The Many Methods of Religious Coping: Development and Initial Validation of the RCOPE.” *Journal of Clinical Psychology*, 56 (4), 519-543.
- Patterson, Amy S. 2009. “A Question of Power: A Christian Political Scientist Responds to AIDS in Africa.” *Christian Scholar’s Review*: 30(2), 231-257.
- Pfeiffer, James 2004. “Condom Social Marketing, Pentecostalism, and Structural Adjustment in Mozambique: A Clash of AHIDS Prevention Messages.” *Medical Anthropology Quarterly* 18(1), 77-103.
- Phiri, Felix. 2008a. “The Spread of Islam in Zambia”. Retrieved from <http://www.africanfiles.org/printableversion.asp?id=17588>.
- Phiri, Felix J. 2008b. “Islam in Post-Colonial Zambia.” Pp. 166-187 in *One Zambia Many Histories: Toward a History of Post-Colonial Zambia*, eds. Jan-Bart Gewald, Marja Hinfolaar, and Giacomo Macda. Koninklijke Brill, NV. Leiden, The Netherlands.
- Sandøy, I. F., K. Dzekedzeke, and K. Fylkesnes. 2010. “Prevalence and Correlates of Concurrent Sexual Partnerships in Zambia,” *AIDS Behavior*, 14: 59-71.
- Shabongo, Nakubiana. 2013. “Zambia: 185 Infected by HIV Daily in Lusaka.” 26 June, 2013. *Times of Zambia*. Retrieved from <http://allafrica.com/stories/201306270264.html>.
- The United States President’s Emergency Plan for AIDS Relief. 2011. “Defining the ABC Approach.” Retrieved from: <http://www.pepfar.gov/guidance/75837.htm>.
- “Tolerance and Tension: Islam and Christianity in Sub-Saharan Africa.” 2010. Pew Charitable Trusts. Retrieved from <http://www.pewforum.org/files/2010/04/sub-saharan-africa-full-report.pdf>.
- Trinitapoli, Jenny. 2006. “Religious Responses to AIDS in Sub-Saharan Africa: An Examination of Religious Congregations in Rural Malawi.” *Review of Religious Research*. 47: 353-270.
- Trinitapoli, J. 2009. “Religious Teachings and Influences on the ABCs of HIV Prevention in Malawi.” *Social Science and Medicine*, 69 (2): 199-209.
- Trinitapoli, J. 2011. “The AIDS-Related Activities of Religious Leaders in Malawi.” *Global Public Health*, 6 (1):41-55.
- Ucheaga, D. N. 2010. “Religious Leaders’ Response to AIDS in Nigeria.” *Global Public Health*. 5: 611-626.
- Underwood, Lynn J. and Jeanne Teresi. 2002. “The Daily Spiritual Experience Scale: Development, Theoretical Description, Reliability, Exploratory Factor Analysis, and Preliminary Construct Validity Using Health-related Data.” *Annals of Behavioral Medicine*, 24 (1), 22-33.
- UNICEF. 2011. “Zambia: Statistics.” Retrieved from http://www.unicef.org/infobycountry/zambia_statistics.html
- USAID. 2011. “HIV/AIDS Development Challenges.” Retrieved from <http://www.usaid.gov/zm/hiv/hiv.htm>.
- U. S. President’s Emergency Plan for AIDS Relief and the Role of Interfaith Health Program. 2012. “A Firm Foundation: The PEPFAR Consultation on the Role of Faithbased-Organizations in sustaining Community and Country Leadership in the Response of HIV/AIDS.” Retrieved from <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCoQFjAA&url=http%3A%2F%2Fwww.pepfar.gov%2Fdocuments%2Forganiz>

[ation%2F195614.pdf&ei=TY_ZUqjTAaPisASfmlGgDg&usg=AFQjCNFbeG0TqUc0eq_RvfzhjsSIEV14A&bvm=bv.59568121,d.cWc](#)

World Health Organization. 2007. "Faith-based Organizations Play a Major Role in HIV/AIDS Care and Treatment in Sub-Saharan Africa." Retrieved from <http://www.who.int/mediacentre/news/notes/2007/hp05/en/>.